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ABSTRACT

This bulletin is an overview of research that explores stress and suicide and its impact on the lives of American youth. Chapter 1 examines student-environment interaction as a means of identifying factors that contribute to students' feelings of distress or perceived inability to cope with their internal or external world. Chapter 2 presents research findings and examples of what schools can do to help students cope with their world. Chapter 3 describes some current programs and offers an appraisal of what some schools are doing. The final chapter recommends steps schools can take to develop programs that alleviate distress and reduce the likelihood of student suicide attempts. Appended are 14 resource agencies; 19 reference; and a list of 11 interviewed professionals. (SI)

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STUDENT STRESS AND SUICIDE How Schools Are Helping

Thomas E. Hart

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February 1989 Volume 32, Number 6

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STUDENT STRESS AND SUICIDE

How Schools Are Helping

Thomas E. Hart

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Preface

Adolescence once was considered a carefree time when youngsters who are members of a loving family nestled in a supportive community go off to school to prepare for life. Increasingly, this belief is being seriously challenged. Reports of social and psychological pressures that confront children from kindergarten to high school run counter to this idyllic view of what it is like to be a young person today.

The pressures felt by young people can sometimes overwhelm them, causing them to become greatly distressed, doubt their own abilities and worth, and, in increasing numbers, turn to suicide as a means of escape. For the student, schooling is part of life, not merely preparation for later life. The schools, then, should assume some of the responsibility for helping students to cope with and enjoy their lives.

In this *OSSC Bulletin*, Tom Hart presents an overview of recent research that indicates that the contemporary student faces far more social and academic pressures than most adults realize. To provide school administrators with information about how some districts have met this challenge, Hart describes some recently developed programs that help youngsters cope with social and academic demands and apparently reduce suicide attempts.

Tom Hart is an OSSC graduate research assistant and a doctoral student in the Division of Educational Policy and Management at the University of Oregon. He has held a number of chief administrative positions in international and overseas schools.

Philip K. Piele
Executive Secretary

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Introduction

Alarming statistics often stimulate action. It is not surprising, therefore, that as educators became aware that suicide is the second leading cause of death among adolescents (after motor vehicle accidents), and as the media focused increasing attention on the many forms of stress that confront children, the schools began to develop cocurricular support systems and curricular materials to deal with these problems. At present, however, the problems are growing more rapidly than the solutions.

In Dallas, Texas, a suicide attempt by a five-year-old boy was averted when his eight-year-old brother dialed the hotline to the Suicide and Crisis Center. According to Dr. Lawrence Brain of the Psychiatric Institute of Washington, D.C., 80 percent of children age 5 through 13 who were admitted to the institute over a two-year period were clinically depressed, were experiencing suicidal thoughts, or had attempted suicide (Brophy 1986).

To identify the role of schools in dealing with adolescent suicide, Kent S. Cochran and A. Lynn Turner (1986) surveyed 114 selected Texas secondary school principals. More than one-third of the school districts (34.2 percent) had experienced serious suicide attempts in the two years preceding the survey, but only 30.7 percent of the districts conducted inservice education on suicide awareness. Jerilyn Pfeifer (1986) reports that nationwide an average of 1,000 young people attempt suicide every day, and, of these, 17 are successful. Paul Rohde of the Oregon Research Institute says that at any time 2 to 4 percent of teens are clinically depressed and that 10 percent of teens have a depressive episode each year.

State legislatures are acting to coordinate the activities of state agencies and schools to deal with these problems. In Wisconsin, state representative Margaret Krusick became aware of the youth suicide problem in that state and introduced a youth suicide prevention bill that was passed by the 1985 legislature. She now believes that the collaborative efforts of the State Department of Public Instruction and the State Department of Health and Social Services have given direction and leadership to that state's youth suicide prevention effort (William A. Berkan 1986).

In California, legislation passed in 1983 mandated a comprehensive

curricular approach to the related problems of depression and suicide. In New York, the lieutenant governor in 1984 cochaired the National Committee on Youth Suicide Prevention that has evolved into the Youth Suicide National Center (headquartered in Washington, D.C.) that compiles information about youth suicide prevention programs and suicide research projects.

In Oregon, as part of the instructional improvement cycle, the curricular goals for health education will introduce into the next school year topics of stressors (their impact on individual lifestyles and how to cope with them), depression, attempted suicide, child abuse, substance abuse, and other related areas for presentation from kindergarten to grade 11. According to Dr. James Eyman, director of the Suicide Research Program in Menninger Memorial Hospital, Topeka, Kansas, similar programs can now be found across the country. Both California and Florida have state laws mandating such programs. A national law in Canada requires schools to have some kind of suicide prevention program.

Stress and suicide are related. If the pressures placed on youngsters by parents, peers, schools, and themselves are not offset by knowledge about how to deal with these often conflicting demands, students can develop such feelings of inadequacy and depression that they become severely distressed. In response to the pressures they feel, an increasing percentage of youth conclude that they are a burden to others or that they are physically and mentally unable to bear the pressures they experience. Many come to view suicide as their only viable option.

This *OSSC Bulletin* explores stress and suicide and the impact they are having on the lives of American youth. Chapter 1 examines student-environment interaction as a means of identifying factors that contribute to students' feelings of distress or perceived inability to cope with their internal or external world. Chapter 2 presents some research findings and examples of what schools can do to help their students cope with their world. Chapter 3 describes some current programs and offers an appraisal of what some schools are doing. The final chapter recommends steps schools can take to develop programs that alleviate distress and reduce the likelihood of student suicide attempts.

The Contemporary Student's Environment

This chapter provides a brief overview of what adult researchers are discovering about the child's world. As Beth Brophy (1986) indicates, a host of psychological pressures have replaced the physical stresses with which previous generations had to contend. It is no longer true that most students come from two-parent homes where in the past the most potent drugs available were contained in aspirin and cough medicine. In today's society, students have access to a myriad of dangerous drugs. Students encounter social and psychological pressures that would have daunted adults of a generation ago.

The Changing Home Environment

Major changes have occurred in the family structure during the past several years. Jerilyn Pfeifer (1986) points out that not only has the extended family disappeared, but it is likely that both parents are working or that the child lives with a single parent who must work. Separation and divorce are also more common and can affect children profoundly. Brophy cites sources who predict that three out of five children born today will live with a single parent by age 18. In fact, only 20 percent of families with children are composed of fathers as breadwinners, mothers at home, and children under 18, compared with 41 percent ten years ago.

These figures mean that most children are likely to experience a change in family structure before becoming legally independent. And when children live in a single-parent home, Brophy points out that they are often expected to assume the role of the absent adult by doing household chores and caring for younger siblings. According to Ynolia Bell Trammell, elementary counselor of John Codwell Elementary School in Houston, Texas, "some of these children lead two lives. They're grown-ups at home and they

come to school to be children" (Brophy 1986).

Many families with two breadwinners rely on daycare. Nationwide, at least seven million children are cared for in family daycare homes or in childcare centers. Babysitting a child in someone else's home for a fee accounts for about three-fourths of all childcare outside the home, according to Brophy. David Elkind, Tufts University child psychologist and author of *The Hurried Child: Growing Up Too Fast Too Soon* (1981), believes that sending children under age 3 to daycare is more stressful for the kids than staying at home with a parent or a familiar babysitter. Separation anxiety, combined with the pressure of a competitive program, exacerbates tension.

A recent study by the University of Michigan Institute for Social Research, reported by Brophy, found that working mothers spend an average of eleven minutes daily of quality time (defined as exclusive playing or teaching) with their children during weekdays and about thirty minutes per day on the weekends. Fathers spend about eight minutes of quality time with their children on weekdays and fourteen minutes on weekends. Nonworking mothers spend thirteen minutes per day of quality time with their children.

Societal Changes

Pfeifer also notes changes in the world of work and communications. She points out that today's technological revolution may cause some jobs that students are interested in to become obsolete before the students graduate from high school. Children may also share in the frustration of parents who are forced to change jobs or are unemployed for extended periods. This brings a harsh sense of reality when such changes require lifestyle decisions that may reflect on a person's "worth" as defined by the success code of whether or not one attains the "good life." This adult consideration filters down to students in the form of attaining good grades or being accepted into the right peer groups.

According to Lori Peters (1986), our highly competitive society puts pressure on teens to succeed, often forcing them to set unrealistically high personal goals. Academic pressures may mount on high school students who believe they must be accepted into Ivy League schools (or else be considered failures). Kelli Schwab, coordinator at South Eugene High School, agrees; in her school, where 80 percent of the students go on to college, the academic and parental pressure is tremendous. Sometimes the parents' expectations are greater than the students'. Some students who will be attending colleges or universities within Oregon feel ashamed that they are not going to be attending highly competitive out-of-state institutions. In our affluent society that emphasizes immediate results, adolescents are not taught to be tolerant of frustration. The success code, Pfeifer states, tells

teenagers that unless they achieve, they are not valuable. Sad, too, are the parents who have achieved but still cannot accept themselves as worthy

individuals without some new success trophy.

Population shifts are also occurring with a renewed migration from rural to urban areas. Students forced to make lifestyle changes because they move from one environment to another may not be able to cope and may use drugs to escape.

Substance Abuse

Use of alcohol and other drugs is prevalent among youth today. Whether emulating adult role models observed at home or on television, or being introduced to substances by their peers, increasing numbers of younger students are experimenting with and becoming habitual users of drugs. Brophy quotes Catherine Bell, chief of the National Institute of Drug Abuse (NIDA) prevention branch, saying, "It's not uncommon to find kids initiating alcohol or marijuana use at ages 9 or 10."

In addition to the widely publicized physiological effects of substance abuse, two social consequences also result. The first is that the user does manage to "escape" and distance himself or herself from reality. This can be the stepping stone to a later conclusion that isolation and suicide can be the ultimate break from distress. The second social consequence is conflict created by the "double standard." This occurs when a child is told by a parent or authority figure not to use alcohol or other drugs, but then observes (or is told by someone else) that the same person is a habitual drinker or user of marijuana or cocaine. Then the child is put into the position of deciding for himself or herself what is acceptable. If this decision is being faced by a nine-year-old, it will be traumatic regardless of the choice that is made.

Current social efforts to make students aware of the dangers of substance abuse are honest attempts to confront the problem but at the same time they can produce further conflict. When one "just says 'No'" but then faces the prospect of isolation from peers and does not find any suitable alternative social interaction, the feeling of isolation is reinforced.

The Success Code

Being successful is a primary American value. This carries down to students in how they think they must plan their lives in order to attain the ideal image of success. Pfeifer compiled lists of success codes for women and men that she gleaned from advertising and television. Although she expected her youthful audiences to laugh at these caricatures of success, they did not. The youth accepted the items and said they felt pressure to meet these "success" requirements. For example, if one wanted to be a successful adult female, one must be able to check off the following items: advanced college degree; full-time, upwardly mobile career; beautiful; successful

husband or chooses to be single; 5'6" or above in height; thin; perfect children delivered by Lamaze; expensive jewelry, clothes, perfume, house, car; beginning salary of \$30,000; glib, funny, but never raucous; brilliant; gourmet cook; does needlepoint in spare time; jogs and plays tennis; active in children's organizations; family well dressed at all times; children never get sick; uses coupons at the grocery store; skillful in writing poetry or painting.

The list for men is similarly exhaustive: college degree in law or business; at least 6' tall, preferably taller; beautiful wife/girlfriend(s); 180 pounds in weight, or 200 if muscular; jogs; expensive car, ring, watch, clothes; perfect children; starting salary of \$30,000; glib, funny; brilliant; strategist; hair styled (or permed); beard if desired; plays golf; self-taught carpenter for hobby projects; can retire early; can discuss at will the stock market, foreign policy, financial portfolios; builds deck in back yard.

I have included the complete lists so that the reader can identify how some youngsters may (even at very young ages) fix on one or another item on the list as either what makes their parents (and therefore their families) worthwhile. When such fixation occurs, and the focus is removed for whatever reason, acute distress results. The distress may not be based on reality, but on one's perception of reality. For example, the student whose parents sell their aging European sports car and purchase a station wagon may feel a loss of status with peers because the symbol of that status has been removed. Similarly, even the parents' choice of exercise (cycling or backpacking as opposed to playing tennis or golf) may affect children's sense of their peers' approval. While educators would like to minimize these considerations in the school environment, they do exist, and for the child they are as real as, and can influence, academic efforts.

Other Factors

Pfeifer lists four additional factors that contribute to the contemporary youth environment. The first is an unrealistic view of death and aging. Because there is less contact with members of the extended family, children may not feel the loss of a grandparent who is only seen infrequently. Coupled with this is the violence prevalent on television, which can desensitize viewers to the reality or finality of death.

A second factor is the nuclear threat, which contributes to a feeling of having no control over what happens. Regardless of what one does, destruction can occur at the whim of people beyond one's control. A third is lifestyle decisions that put pressures on adolescents to face decisions that formerly may have been answered for them by parents or community mores. For example, women have more career options, can choose whether to marry or remain single, and can decide whether to have or not have children. Moreover, divorce is an increasingly acceptable option. The fourth factor Pfeifer cites—academic pressures—has been referred to above.

In his book *Adolescent Suicidal Behavior*, David K. Curran (1987), a teacher and clinical psychologist, lists an overlapping set of factors. He believes that suicidal behavior among today's youth is accounted for by our stressful, fast-paced lifestyle; an extended adolescence that is more complex and less supervised than in times past; and the slow disintegration of the family. He also contends that teenagers see around them a society that lacks any firm adult consensus on the issue of suicide. As a result, many young people imagine suicide is an acceptable means of solving their problems.

Brother Eagan Hunter (1988) contends that "social scientists believe there is a direct relationship between the increase in suicides—especially adolescent suicides—and the decrease in social solidarity." He believes that children experience less of the traditional security and support of family life during the critical growing years. Until these disruptive factors change, educators must help young people cope with the stresses of our society and try to reduce the suicide-producing factors within school populations.

During a telephone interview, Myra Herbert, chief social worker for the Fairfax, Virginia, public schools, pointed out that today's students have to deal with issues that the last generation didn't have to face. Some parents want to deny that this is the case. Consequently, they ignore the problems and fail to work them through with their children, who must grapple with them alone.

The Child's Perspective

The information presented in this chapter probably will not startle the adult reader. Except for some statistics, the reader may already be familiar with the trends described. But what we adults must be able to do is to put this information into the perspective of children who must cope with and are being formed by their ever-changing environment. Children do not contemplate the "fact" that three in five of them born today will live with a single parent by age 18. Rather, those whose parents divorce experience a destruction of their world. They do not know that their (or their friend's) moving to another city is merely an iota of a prevalent demographic pattern. Rather, they just know that they won't see their best friends or favorite tree again — ever.

Children do not function only on a rational level—accepting fact that drugs are harmful. If they do not use drugs, they experience the reality of not having the friends or being in the group they had identified as being role models and worthy of emulation. They (and many adults, as well) do not realize that the "success code" is an advertising ploy and that few people realize that image, or that others refuse to become caught up in the race to a futile and empty American dream. They only know that they, or their parents, do not have or do what "everybody else" has or does, and this contributes to lack of self-esteem and raises questions about their worth.

What adult educators must realize is that the perspective of the child in contemporary society does not change when he or she hears "You'll get over it" or "You'll understand better when you're older." For the child, life is now. Distress is felt now. Something must be done now. Can I get help now? Who can I go to now? Whoever or whatever is available for support is what will be influential. Schools can provide partial support, and increasing numbers of schools are doing so.

Strategies to Help Students Cope

In recent years numerous articles have suggested that schools must become more responsive to students' psychological needs. Stress management, suicide awareness and prevention, and coping with crisis are all topics around which staff inservices, cocurricular materials, and curricula have been proposed. Rather than discuss numerous specific programs, this chapter presents overviews of strategies to increase students' coping skills and reduce the incidence of suicide attempts. These strategies are staff and student awareness training, means of identifying and assessing students at psychological risk, referral of students to outside agencies, and school-based curricular and support programs.

Awareness Training

If a school or district believes that it is necessary to have a stress management or suicide prevention program, but does not have the personnel or the finances available to initiate a comprehensive program, awareness training is an effective first step to take. Kelli Schwab at Oregon's South Eugene High School states that if a school wants to start a program, it should start by educating the staff. All the people interviewed for this Bulletin as well as numerous written sources agree that administrative, staff, and student awareness and support are essential elements of any such program.

David Curran (1987) believes that school personnel can play an important role in saving teenage lives. He notes that alert teachers often are the first to identify suicidal students, and quick action by a teacher could make the difference between life and death.

Curran also emphasizes the importance of adult awareness of teenage suicidal behavior, claiming that adults often fail to recognize the warning signs of suicidal behavior, and in some cases adopt a disapproving, hostile

attitude toward young survivors. Some adults try to ignore the suicide attempt rather than face the issues that led to it; others show hostility or maintain an emotional distance from the would-be suicide.

As a result of working with administrators, teachers, counselors, and students in two diverse school districts, Charmaine Boggs (1987), of the Suicide Prevention Center, Inc., in Dayton, Ohio, says that

inservice of school personnel is essential prior to working with students in the classroom. This inservice should include not only administrators, counselors, and teachers, but also the support staff (nurses, secretaries, aides, maintenance persons, bus drivers) who may be just as likely to encounter a suicidal student.

One essential goal of the staff inservice is to develop a building (or system) wide crisis intervention strategy for dealing with suicidal students.

The emphasis she places on inservice training is echoed by Dr. James R. Eyman of the C.F. Menninger Memorial Hospital. In his opinion, the best programs have well-planned curricula, but "more importantly have training for teachers and school personnel who can recognize the behavior changes and characteristics of students in need of help."

Awareness of Symptoms

Linda Satter, executive director of the Suicide Prevention Center, Inc., stresses the importance of making school personnel aware of the signs of depression or of suicidal intent in students. The center conducts training sessions for school personnel, volunteers, and parents who want to become involved in a formal assistance program or who want to become more aware of the problem because of their positions as educators or parents. The center's *Lifesaver Program Manual* (available from the address in the Appendix) is a comprehensive guide for establishing such a program. The training sessions provide participants with information about the symptoms, not their treatment. In fact, the statement is clearly made to parents, "Recognize that your intervention is limited. Your child needs an objective, helping professional." But teachers and parents can be trained to recognize when a student needs to be referred. According to the manual, symptoms of depression in children/teens include the following:

- temper tantrums
- academic problems
- hyperactivity
- truancy
- school phobias
- eating problems
- boredom
- fatigue
- sleeping problems
- behavioral problems
- severe withdrawal
- running away from home
- accident proneness
- delinquency

Among the symptoms of suicidal intent are

- discussion of suicide as an option to a life situation or crisis

- gathering information about or getting materials for suicide
- previous suicide attempts, gestures, or threats
- giving away possessions; saying good-bye
- self-destructive behavior; drug and alcohol abuse; risk-taking activities
- death themes in music, writing, or art
- dark, heavy, slashing lines and/or unconnected body parts in doodles and artwork
- expressions of hopelessness, helplessness, alienation, and anger at self and the world
- statements that they would not be missed; would be better off dead, etc.
- sudden dramatic behavior change; especially positive change after depression

Because the above signs can also represent normal adolescent behavior, adults should watch for a cluster of symptoms or repetition of a symptom over time, either of which may indicate abnormal behavior and the need to seek professional counseling for the child. But the important thing is to realize that anybody can be taught to recognize symptoms.

In an evaluation of the Project Lifesaver programs in two Montgomery County, Ohio, school districts, Boggs reports that the results of the pre- and post-assessment surveys of elementary and secondary teachers "provide strong evidence of the success of the Project Lifesaver staff inservice programs. Ninety-two percent of the elementary and 100% of the secondary teachers who responded. . . would. . . recommend such an in-service to other schools." The post-assessment surveys also showed gains in the ability of teachers to recognize those symptoms of childhood and adolescent depression and suicide that are often overlooked. There were also considerable gains in accurate knowledge about suicide, particularly with regard to children and adolescents.

Inservices are also being conducted throughout Wisconsin by Jeanne Harper, a consultant for the Wisconsin Department of Public Instruction. The inservices deal with what suicidal ideation is, what constitutes a suicidal threat and a suicidal gesture, what a suicidal attempt is, and the completion of an attempt. Harper believes that the type of intervention needed depends on the nature of a student's behavior—that is, whether there is a "threat" as compared to a "gesture."

In a second set of workshops currently being organized, Harper will address how students can be integrated back into the school system after a threat, gesture, or an attempt. She brings to the attention of her audiences her book written for teenagers, *Hurting Yourself*, intended to help students who have threatened, gestured, or attempted suicide. She firmly believes that not enough attention is given to reintegrating the students who have attempted suicide. Parents, counselors, and teachers should be sensitive to such things as what it is like for a student to use the bathroom where a few days earlier

he or she attempted suicide.

Peer Counseling

Some schools have recently begun training students to be aware of potential problems among their classmates. Peer counseling was recently reported in *Newsweek* (Connie Leslie October 31, 1988) as being successfully practiced in a number of schools across the nation. Although there is some skepticism among professionals about the effectiveness of this approach, it is endorsed by the Suicide Prevention Center. In a review of the research literature in its *Lifesaver Manual*, the center states,

In summary, research shows fairly conclusively that lay counselors can be as effective or even more effective than counselors who have completed traditional academic programs and are considered professionals. (1988)

The center conducted a small experimental study in 1982 using 235 students at one Dayton, Ohio, high school. The study indicated that the students who had received a program on suicide prevention were significantly more likely to recognize signs of suicidal behavior and were also more likely to share that information with a teacher.

According to the *Newsweek* article, a factor contributing to the success of some peer counseling programs is that the prospective student counselors receive intensive training for what they will be expected to do. For example, at Druid Hills High School near Atlanta, students are required to take a twelve-week, noncredit course. At Hillcrest High School in Queens, New York, peer helpers take an eighteen-week course for academic credit. The personnel cited in the article were enthusiastic about their programs. They believed that peers can be very effective in both discovering problems that are not detected by school personnel and helping to obtain professional assistance for their classmates (Leslie 1988).

When there has been an inservice (or a series of them for the various members of the school population), participants in the program become alert to problematic symptoms. This is the first step in determining who is in need of more formal assessment and counseling.

Identification and Assessment of At-Risk Individuals

In addition to awareness training, another strategy that schools can use to help depressed and suicidal students is an assessment instrument, which can be administered to all students on a regular (usually annual) basis. Students whose scores indicate the advisability of a followup counseling session can be screened by qualified district personnel. Districts interested in obtaining more information about diagnostic instruments can contact The Psychological Corporation and the Center for Cognitive Therapy (addresses are in the Appendix) for catalogues of materials. Following are some examples of

diagnostic inventories developed by Aaron T. Beck, director of the Center for Cognitive Therapy.

Beck Depression Inventory

Depression is one of the initial signals that professional help might be advisable. Although students may cover feelings of depression by increased activity, or by assuming an aggressive or conciliatory role, they might candidly respond to an inventory that is given as a part of a health course or a diagnostic screening. The Beck Depression Inventory presents the student with twenty-one groups of statements, and the student is asked to select the one statement in each group that best describes the way he or she has been feeling the past week. For example, the following statements are listed in group 11:

- 0 I am no more irritated now than I ever am.
- 1 I get annoyed or irritated more easily than I used to.
- 2 I feel irritated all the time now.
- 3 I don't get irritated at all by the things that used to irritate me.

And, in group 18:

- 0 My appetite is no worse than usual.
- 1 My appetite is not as good as it used to be.
- 2 My appetite is much worse now.
- 3 I have no appetite at all anymore.

These groups assess two of the behaviors that were cited earlier as symptoms of depression: temper tantrums and eating problems. Other groups of statements assess other items on that and the suicidal intent list. The developer states that the inventory has been validated as a self-administered as well as an interviewer-administered instrument.

After the student has completed the inventory, the scores are totaled and then compared with the following suggested ranges.

- 0 - 9 Normal range
- 10 - 15 Mild Depression
- 16 - 19 Mild-Moderate Depression
- 20 - 29 Moderate-Severe Depression
- 30 - 63 Severe Depression

If the student's score is fairly high, he or she could be referred to a suitable agency or analyst for a more thorough assessment.

Beck Hopelessness Scale

One of the primary signs of a suicidal intent is the feeling of hopelessness-

ness. Beck's hopelessness scale consists of a list of twenty statements. The student is asked to write "true" if the statement describes his or her attitude for the past week. If it doesn't, then he or she responds "false." Some examples of the statements follow.

I look forward to the future with hope and enthusiasm.

I just don't get the breaks, and there's no reason to believe I will in the future.

When I look ahead to the future I expect I will be happier than I am now.

There's no use in really trying to get something I want because I probably won't get it.

For every statement, a score of 1 is assigned if the test-taker's response agrees with the answer key (the pessimistic answer). The maximum pessimistic score for feelings about the future is 20. Nonmatching responses are scored 0. On the basis of comparing respondents' scores on the inventory with an independent clinical assessment of the test takers' depth of hopelessness, the following scale was proposed for rating hopelessness:

- 0 - 3 None or minimal
- 4 - 8 Mild
- 9 - 14 Moderate
- 15+ Severe

Again, referrals can be made when warranted.

Stress Scale

In *The Hurried Child*, David Elkind (1981) provides a stress scale that gives points for stress-producing incidents. The student checks off all the items that apply, and a total score is tabulated. Some sample items and their point values are given below:

<i>Stressors</i>	<i>Points</i>
parent dies	100
parents divorce	73
parents reconcile	45
theft of personal possessions	30
moves to another city	26
vacations with family	19
change in amount of TV	13
birthday party	12

If the total score of all marked items is less than 150, the stress is about average; if between 150 and 300, the person will probably show symptoms of stress; and if the score is above 300, there is a strong possibility that the person will experience serious changes in health or behavior.

Jeanne Harper developed a "fact sheet" that students complete. Schools that have used the fact sheet have found that the students who threaten or gesture suicide tend to identify themselves as coming from families that are dysfunctional or are facing serious problems. Schools can use the fact sheets to identify factors that are specific to their communities and that seem to be common among students who have come for counseling or have made suicide attempts. Using this background information, a profile can be suggested that will then be used as a screen to flag future students who have this pattern in their responses.

Summary

The above examples are not exhaustive (for example, Beck has also produced an anxiety inventory and a suicide ideation evaluation) but do indicate that simple instruments can serve as one indication that a student may be at risk. When the test results positively correlate with staff observations, referral to treatment is advised. As was stated at the beginning of this chapter, if the district does not have the professional resources available for further counseling, the students can be referred to outside agencies or professional psychologists.

Referral to Outside Agencies

Using resources outside the district may be necessary even if the district has its own counselors, either because of the severity of the problem and the amount of time that will be required to attend to a single student, or because the counseling staff do not have the training or expertise to provide indepth, long-term psychological counseling.

Most larger urban areas have counseling centers and crisis hotlines intended to deal with referrals from the community at large. Schools can contact these sources and request that a representative come to classes to explain the work they do. Personnel at a number of such centers interviewed for this Bulletin work closely with the schools in their areas.

Some districts or schools have specific individuals or agencies to which they can refer troubled students. For example, South Eugene High School has two staff counselors who also have private practices. Students and their families are entitled to four consultations without charge. If more sessions are needed, the student is referred to another professional not associated with the school.

This same school also invites a local psychologist, Dr. Jon Garlinghouse, to come to the school to conduct a workshop for students and parents. The primary message of his presentation is "It is OK to be average." In this highly competitive school, however, some parents admittedly don't "buy" the message, according to Kelli Schwab, the at-risk coordinator. Garlinghouse agrees and warns that the national drive for "excellence" in schools is causing stress among students, particularly those with good academic ability. "Students," he says,

believe everybody has such great expectations for them. If they are not doing so well in any aspect of their academic or social lives, they are afraid that their parents or the community will become aware of it. They cannot bear facing the disappointment, and commit suicide. They are never told that nobody can be excellent in all aspects of their lives.

Garlinghouse believes that the "average student" faces a similar problem. If he is constantly told he must do better, he gets the idea that he isn't fulfilling expectations. But, as Garlinghouse points out,

Average is what America is all about. What people are doing, however, is equating "average" with "mediocre." Students can raise their average once they accept that being an average kid is good enough. We must deemphasize the "star" quality that comes through the media, and respect "average."

Research agencies such as the Oregon Research Institute (ORI) that can provide specific, specialized services are available in some areas. One program at ORI discussed in the next chapter is the Adolescent Coping with Depression Program.

School-Based Programs

As adults become more informed about stress management and suicide prevention, information about these topics begins to be incorporated into school health curricula. This may be because it is mandated by a state or district administrative decision, or because classroom teachers elect to include contemporary topics in their class presentations. In Oregon, for example, as part of the statewide instructional cycle for common curricular goals, the new health curriculum, to be implemented in 1989-90, addresses a diverse range of topics that focus on the total person, integrating the physical, social, emotional, and environmental components of human experiences.

Four strands run through the K-11 program: safe living, stressor/risk-taking management, physical fitness, and nutrition. The strand dealing with stressor/risk-taking management was created to provide a

flexible learning environment which effectively handles a wide range of difference in the stress handling abilities of children. This environment will enable each child to learn to effectively handle the stressors in life. (Oregon Department of Education 1988)

More details about this curriculum will be provided in the next chapter.

The program in Wisconsin also focuses on four areas that are dealt with from kindergarten through twelfth grade (William A. Berkan 1986). These are alcohol and drug abuse, depression, self-esteem, and feelings and fears. The topics discussed vary according to the age of the students. Suicide is not even mentioned before seventh or eighth grade, because it is felt that younger students would not be mature enough to deal with the issue. However, just by dealing with these areas in the lower grades, suicide prevention is being addressed. Harper believes that by talking about coping skills throughout the school years, children acquire increasingly complex models to use for the ever more difficult problems they have to deal with as they mature.

Programs in Wisconsin begin in kindergarten by dealing with stress as it relates to students who have to cope with the loss of a pet or other grief-producing experiences. Students learn that the emotions they feel are a part of life and are okay to have. In this fashion, distress management and coping skills are taught at a level the students can understand.

The Project Lifesaver Program in Dayton, Ohio, is a school-based program that provides inservice education for school staff and parents (Suicide Prevention Center 1988). Elementary-level classroom programs include puppet shows, discussion sessions, and other activities. At the secondary level, programs include single and extended classroom presentations, a stress management course for junior high students, and class discussions of grief and death. Additional programs deal with postsuicide attempts and deaths.

Each aspect of the Project Lifesaver Program is based on research findings and experience of what was effective at the different levels. For example, the secondary school programs were developed for use in grades 7-12, because the research indicated a significant increase in suicidal behavior at the eighth-grade level, suggesting that intensive suicide prevention efforts should begin before the eighth grade. In addition, field experiences showed junior high students tend to be enthusiastic participants in role plays and, as a whole, tend to be far more willing to share feelings and opinions openly and during class discussions than do older adolescents. Having the exercises at this lower secondary level also allows for "refresher courses" or suicide prevention materials to be used in high school, either for distinct courses or as sections of sociology, psychology, anthropology, child development, and family living courses.

Characteristics of Suicide Prevention Programs

A survey conducted for the American Association of Suicidology by Dr. Kim Smith and associates (1988) at the Menninger Clinic revealed characteristics of a number of suicide prevention programs associated with

schools in both the United States and Canada. Of the 114 programs featured in the survey, most were based either in schools (33.4 percent) or crisis centers (28.1 percent), with the fewest in private practice (1.8 percent) and none in psychiatric institutions. Ninety-four had programs that were essentially curriculum-based and classroom-centered. Some programs begin in kindergarten, but others only in the eleventh grade. Seventy-two percent of the curricular programs were developed by staff members.

The typical classroom suicide prevention program uses a formal curriculum, the survey found. The fourteen most common topics (in decreasing order of frequency) are as follows:

- myths, signs, facts, and symptoms
- learning about referral sources
- identification/acceptability of feelings
- how to respond to a suicidal crisis
- stress management/coping/problem solving
- communication skills
- the nature of ambivalence
- motivations for suicide
- the nature of depression
- risk assessment
- mourning/bereavement
- philosophical issues (e.g., "right to die")
- the realness of death
- religious/moral injunctions

The teachers presenting the classroom instruction received an average of three-and-one-half-hours of specialized training in the area.

About a third of the programs reviewed had a component directed at imparting information about suicide to community gatekeepers, school personnel, and other interested parties. The goal of these programs is to supply interested community and school personnel with information about suicide so that they can then teach others this information and/or identify those students at risk for suicidal behavior.

About a quarter of the participants in the study reported having a peer support component. This refers to nonclassroom, student-to-student tasks designed to identify or stabilize and refer other troubled students. These programs often teach befriending and listening skills. The eighth grade was the average grade level at which peer support programs were begun. On the average, students met 14.7 times a year and received an average of 11.5 hours of training. About half of the training was performed by outside experts and experienced students, and most of the other training was done by school personnel. Generally, the students meet as a group at least monthly to discuss their experiences, and each student is supervised by a trained adult.

About three-fourths of the participants reported having some form of crisis intervention program, which was defined as "active interventive ef-

forts" rather than simply teaching students or adults about what to do during a crisis. The typical crisis team had five people who receive seven hours of training. Most of the crisis team's effort and time is spent in evaluating suicidal risk and counseling high-risk students. The program is typically conducted through a mental health center or a crisis intervention center. Usually a contractual agreement exists between the school system and the agency that provides crisis intervention programs.

Four of the 114 programs reported that they did not teach or attempt crisis intervention, but instead focused on screening for significantly depressed or suicidal students. One participant used completed depression inventories to screen students. A second taught classroom teachers to identify the significantly depressed or suicidal student. The third focused on teaching nonclassroom personnel such as nurses, social workers, and counselors to assess students. Another program trained students to identify depressed peers and to refer them to counselors for further evaluation.

The authors of the report express four concerns based on the findings of their survey. First, a number of programs are operating without adequate evaluation. Second, some peer support programs do not have the school's formal approval or the overt approval of the parents. Third, some peer support programs put students in inquiring roles with potentially imminently suicidal students without providing them with clear referral procedures. And finally, there are poor evaluation efforts and no minimum standards established (as could be done by the American Association of Suicidology) for content, supervision, and program evaluation. One suggestion they make is that programs could best be evaluated on the basis of the proportion of youth who contact available resources before acting. The authors also believe that school programs should have a screening component that could have two bases of assessment: how adequately they identify troubled youth, and how effective they are in providing help to those identified as being at risk.

The next chapter presents details of some programs that deal with depression and suicide prevention.

Examples of Depression and Suicide Prevention Programs

Among the wide variety of programs available for presentation, I have selected three types for consideration: an outside research institute, programs working through schools, and a comprehensive districtwide effort.

The Oregon Research Institute

When districts are aware of students who need counseling, but feel that their own staff are not able to deal with the particular problems some students have, they look to outside agencies for assistance. According to Paul Rohde, the Oregon Research Institute (ORI) provides this type of assistance to some Oregon schools through its Adolescent Coping with Depression Program.

With funding from the National Institute of Mental Health, ORI is conducting a research program designed to provide depressed adolescents with skills and techniques found to be useful in overcoming depression. The program is a modification of an adult program that has been operating successfully for sixteen years. Fourteen-to-eighteen-year-old high school students are eligible for the program. The following techniques are used in the program:

- relaxation training
- constructive thinking
- increasing pleasant activities
- social skills training
- negotiation and communication skills training
- problem-solving skills training

assertiveness training

Since this is an experimental study, not all adolescents who are referred by schools or who apply individually or through their parents will qualify. For example, if they currently have a substance abuse problem, are currently receiving other psychological/psychiatric treatment, are mentally retarded or have organic brain syndrome, are an imminent suicide risk, or exhibit significant antisocial or law-breaking behavior, they will be excluded from participation. Before entering the depression program, students in these categories must seek appropriate specialized treatment.

For students who qualify, a comprehensive assessment of their psychological status is conducted, and then they are assigned to groups consisting of six-to-eight members. The groups are divided into three categories. In the first category, both the students and their parents attend parallel sessions. Twice each week for eight weeks the teens meet in the early evening for two-hour sessions. Their parents meet eight times (once a week) for two hours with ORI personnel to learn about adolescent depression and about the skills their teenagers are learning to gain control of their moods.

Students in the second category attend the same series of meetings as the first group, but their parents are involved only during the intake interviews. Third-category students have to wait two months before receiving treatment. This is essentially a control group to see if no professional intervention, but only an elapse of time, can help to resolve the depression.

To provide additional support, some groups may meet for booster sessions following the course. Followup interviews will be conducted with the students over a two-year period to assess the long-term effectiveness of the program. As with other programs of this type, initially most participants will feel that they have been helped, but later they may suffer a relapse when they no longer have the support that was available through weekly group meetings.

Both schools and parents have shown interest in the program, which at present is limited to 100 students each from the Portland and Eugene areas. ORI hopes to expand the offerings in the future.

The program has many advantages. It is a low-cost form of treatment (only a refundable contingency deposit of \$25 is required of participants). Since it is presented as a workshop, the program lacks the stigma sometimes associated with therapy. In fact, it could be used by a qualified school counselor who can be trained by ORI. It also has the potential for being used in the schools as a prevention program, or it could be developed into a course.

Programs within Schools

Two major kinds of suicide prevention and stress management programs operate in schools. In the category of curriculum and cocurricular

programs, this section looks at South Eugene High School's stress management program; Oregon's Health Education Curriculum; and the Suicide Prevention Center in Dayton, Ohio. Then two peer counselor programs—in Miami, Florida, and Queens, New York—are described

Curriculum and Cocurricular Programs

The previous chapter mentioned curricular and cocurricular efforts that are being implemented in Oregon and Ohio. Although Oregon's curriculum will not be implemented statewide until the 1989-90 academic year, some Oregon schools and districts already have programs in place. For example, Kelli Schwab, the at-risk coordinator at South Eugene High School, has been conducting programs for several years in the district and for three years in the high school.

This year, South Eugene High School has a stress management program for ninth graders. This grade was selected because research indicates that if ninth-grade students miss ten or more days of school during that first year of their high school experience, their chances of graduating decrease markedly. The rationale is that if they can continue to build self-esteem and social and academic skills during that grade, then as they progress through high school they will not get so easily discouraged and will not drop out of school. The stress management program is incorporated in a study skills class that all ninth graders are required to take. The school also invited outside speakers to address the entire ninth-grade class on issues related to self-esteem, including suicide.

A curriculum on death and dying for middle schools (developed by Schwab) is being taught at those levels. Middle schools also have a home visit program. When students are identified by the staff as having problems or are in danger of not graduating, Schwab and other counselors make the home visits so that, as she puts it,

the parents and children will realize that there are adults in the school system who are taking a personal interest in them. In many such cases the family felt alienated from the schools and had a fear of the people in the school treating the youngsters like they're dumb or in such a way that they feel insecure. We try to make them feel comfortable, so that if they feel they need help they will come and ask for it.

Students new to the district are introduced to a parent who has organized a "Newcomers Club." Three or four times a month, the club plans activities for the students, thereby helping them become a group themselves. If the organizer observes that a student has a problem, she advises the counselors, who can follow up with some form of intervention. Teachers of new students also alert counselors if they feel a new student is experiencing difficulty.

The program is not assessed in terms of a decrease in suicides (although since Schwab has been there, not one suicide has occurred in the

school), but by how many ninth-grade students are not advanced to tenth grade. Before the program, about seventy-five students each year repeated ninth grade. This past year that number was down to thirty-two.

Oregon's Stress Management Curriculum. The Oregon Health Education Curriculum has a Stress Management/Risk Taking component based on the idea that illness and death occur when constant "alarm" reactions exhaust the body's response capacities. The assumption is that persons are less likely to develop stress-related illnesses if as children they can be taught how to cope with stress. The challenge for educators is to develop ways to support risk-taking that is necessary for building self-confidence while not supporting taking risks with drugs, sex, fast driving, or other health-and-life endangering activities.

Stress resistance can be learned. Students can be given an effective plan of action that includes problem-solving and creative coping strategies for handling specific stressors while also developing lifestyle plans of action for resting and revitalizing. Specific, significant problems require specific solutions, while the cumulative effects of many small, nonspecific hassles require generalized wellness activities.

The curriculum is divided into a number of goals presented from kindergarten to grade 11. For example, one goal is to teach students to "design and implement a plan to manage lifestyle stressors and risk-taking behaviors" (Oregon Department of Education 1988). In kindergarten, the students name experiences that make them feel happy or sad. In grade 1, they describe how they feel when they share their belongings. In grade 2, they discuss how they feel about doing well in school work and extracurricular activities. In grade 3, they identify stressors and the role their perception plays in determining them as good or bad (for examples, peers, family, school, competition, praise, criticism, self, food, pressure to use drugs/alcohol/tobacco).

Grades 5, 8, and 11 continue the emphasis on stressors and add several other topics. Grade 5 adds physical and emotional changes that occur in adolescence, and grades 8 and 11 address the pressure to become sexually active. Another goal is to "comprehend implied meanings of written, oral and visual communications concerning stressor/risk-taking behaviors." So in kindergarten students name stressors, in grade 1 they define them, and in grade 3 they gather information about them. In grades 4 through 11 they are asked to relate new information to previous knowledge about stressors.

Students "identify problems and approach their solution in an organized manner." The goal is only explicitly dealt with in grade 4, when students begin to share ideas about successful and unsuccessful problem-solving strategies. In grade 6, they solve problems with more than one possible solution and learn to recognize problems that cannot be solved because they do not have enough information on which to base a decision. Students evaluate problem-solving strategies in terms of tools, methodologies, processes, and operations in grades 10 and 11. Within the same grade, activities

are designed to integrate each of the goals.

Ohio's Suicide Prevention Center. In Dayton, Ohio, the Suicide Prevention Center, Inc. has prepared activities for schools to address four levels of prevention: actively intervening to prevent suicide attempts; preventing further dysfunction after a death or an attempt; working with high-risk populations; and addressing those factors that increase the likelihood of suicidal behavior.

For elementary school students, the focus is on accepting and sharing feelings associated with grief and loss and developing a network of adult support. Secondary school programs highlight recognition of suicidal behavior, adult resources, and factual information about suicide. The schools' efforts are directed primarily toward the students, but parents, school personnel, and other adults who work with young people are trained in the basics of suicide prevention and intervention. In fact, before the Suicide Prevention Center makes a presentation to students in a school, it insists that the school staff receive inservice training. This is so that students have a "safety net" in the days and weeks following the classroom presentation.

The *Lifesaver Program Manual*, available from the Suicide Prevention Center (the address is listed in the Appendix), is a comprehensive explanation of the program. It describes the program's rationale and gives the specifics of practice. For example, the focus of the program at the elementary level is on feelings and coping skills related to loss, primarily through death. At this level, puppet shows are presented to communicate to children about self-esteem, feelings, and death and other losses. Teachers decide how many activities will be used for their classes. Other activities include discussions, skits, word games, and collage making.

Efforts at the secondary level are initially aimed at seventh- and eighth-grade students, since research indicates a substantial increase in suicidal behavior among eighth graders. Again, at this level various options are given, such as single-period class presentations; three-day extended class presentations; an eight-lesson stress management program for junior high students; and exercises that facilitate discussing grief and death in the classroom. The program is designed to be suitable for use in grades 7-12. Included are guidelines for teacher presentations, scripts for skits, lesson plans, suggested student activities/projects, and so forth. For all levels, there are also suggestions for how to handle the aftermath of a suicide attempt or a death.

Although it is difficult to assess the program in terms of its success in preventing suicides, initial research shows that it has made students and staff more aware of the problem and of the resources that are available to those who are experiencing stress and may be contemplating suicide.

Peer Helper Programs

Peer Helper Programs, also referred to as peer counselor programs, have been receiving renewed interest as a means of reaching students. The

October 31, 1988, issue of *Newsweek* briefly described several programs and told how they are perceived by the schools in which they are operative. The following descriptions of two of these programs are based on information OSSC obtained by interviews with the program's organizers.

Coral Park Senior High School, Miami, Florida. One of the most successful peer counseling programs is in Coral Park Senior High School in Miami, Florida. According to Mary Ellen Strawser, supervising counselor of the program for the past five years, the program was actually begun about fifteen years ago by a member of the school board who was a pediatrician and who firmly believed in this type of program. It was put into place in every senior high school. But when he died, the program began to deteriorate. For example, some schools combined the supervisor's position with a coaching responsibility, and its impact was weakened. Eventually the program was eliminated. Then, eight years ago, a principal Strawser worked for wanted her to restart the program in his school. She agreed and operated the program successfully but then was called to Coral Park to begin the same program there.

Strawser thinks this type of program is highly effective because "students with problems are more willing to open up with people their own age. Once the initial contact is made and some trust and confidentiality are established, they are willing to see the professional."

Peer counselors in this program are told that if their contact is contemplating suicide, the counselor must contact Strawser, who then intervenes. As she explains,

If the student tells the peer counselor, "I want to tell you this, but don't tell anybody else," the counselor is instructed to tell him or her, "If this is a life-threatening situation, I have to tell Mrs. Strawser." Because students have confidence in their peers and in their confidentiality and the reputation of the program in the school, they will go along with that.

The purpose of the program is to make students with problems aware that somebody is available to help them. The peer counselor serves as a bridge between the student with a problem and the professional counselor. This has been the result in practice. Strawser points out that before the program was active, student referrals came primarily from the teachers and administrators. These continue, but now 80 percent of the referrals come from the students themselves—both the peer counselors and the students with problems.

To recruit participants, Strawser makes a presentation to the eleventh-grade English classes at the end of May, and she asks students interested to sign up for an interview. Last year, over 200 students applied for the 20 peer counselor positions. Initially the school counselors conduct group interviews and then call back applicants for followup interviews until the twenty positions are filled. The counselors attempt to get a mix of students in the group.

For training, the new peer counselors take a psychology course with

Strawser, and they are taught to discern body language and share principles of stress management. They lead discussion groups of twenty-five to thirty students once a week and attend to three clients each term. They also work with students at an elementary school.

The program is part of a multilevel approach for helping students. The peer counselor may be the first person to encounter a student with a problem. If the peer counselor is unable to assist the student, he or she is referred to the school counselor, who in turn may choose to refer the student to a psychologist, psychiatrist, hospital, medical doctor, agency for substance abuse, or some other source of help. If the problem can be effectively dealt with at the lower levels, it is stopped there. Strawser believes the process has prevented the development of serious problems that would have required the involvement of community agencies.

Hillcrest High School, Queens, New York. Another effective program is operated at Hillcrest High School in Queens, New York, under the direction of Lori Barrett. Larry Marcus, who developed and tested the program before it was approved by the New York City Board of Education for use in Hillcrest, describes it as "a comprehensive peer counseling program" that he developed over the past year. The program's foundation, Markus explained,

is an academic course that kids take in peer counseling that includes training in suicide prevention and stress management and prevention. The students are given ninety hours of instruction. The course is unique in that not only does it train students in communication and diagnostic skills, but also in the content area.

At present there are about 40 peer counselors out of a student body of more than 3,300. Students who want to participate as counselors go through a careful screening process after they volunteer or are recommended by a staff member for participation. They are screened again after the course on the basis of their performance in the course and other criteria set for the program. After being accepted, they are supervised by a professional on a weekly basis.

Markus said the peer counselors "are required to make immediate referrals to adult professionals in all cases that are deemed to be crisis interventions—issues about suicide, sexual abuse, or physical abuse."

This program is now being purchased by a number of other school systems for their use. In his opinion, it is easily adaptable to any type of school system, whether large or small, urban or rural. Some schools train seventy counselors a year, whereas others only train ten. He provides followup assistance to those who purchase the program.

Marcus suggests that a school wanting to institute a peer counseling program must be strong in three major areas:

- a careful selection process for student participants

- a good, solid, comprehensive training program
- professional supervision for the students after they have been trained and begun to work with other students

If any one of the above factors is missing, the school is not going to have a strong program. The program can be started by interested counselors, psychologists, or social workers already on a school's staff. But the person implementing or supervising a peer counseling program should have clinical training and a clinical background, that is, be a counselor, psychologist, or social worker, Markus said.

The Limitations of Peer Counseling. Some counselors are justifiably concerned about establishing peer counseling in schools, because, unless the program is monitored by adults with mental health training, students and teachers may not be aware of what is going on and may harm rather than help students in crisis. Also, if there is little professional input, the programs may be perceived as ineffective and fail for that reason. Moreover, if no professional help is available, students who are peer helpers may feel pressure to actively counsel their peers. This puts too much responsibility on the student helper. As Dr. Barry Garfinkel, director of the Division of Child and Adolescent Psychiatry at the University of Minnesota Hospital and Clinic in Minneapolis, puts it, "teenagers make very good diagnosticians, but they make terrible therapists. . . .they simply don't have the mature perspective to provide the most effective help" (quoted by Jack Frymier 1988).

Nor is peer counseling a solution to a shortage of qualified personnel. In fact, an effective program may produce more work for trained personnel, because they must guide and monitor the student helpers and handle the additional crisis cases referred by the helpers.

A Comprehensive Districtwide Model

The most comprehensive districtwide program identified by OSSC is the Adolescent Suicide Prevention Program of Fairfax County Public Schools in Fairfax, Virginia. The program began in 1982 when the school board, in setting instructional priorities for the 1982-83 school year, issued a directive to staff to "work with community resources to address the mental health of troubled students" (Fairfax County Public Schools 1987).

The Fairfax County Public Schools is justifiably proud of its program, and Myra Herbert, chief social worker for the district, has given presentations in "probably forty-five places in the United States." She said that through the years

the program has expanded and been amended so at present there are routine crisis procedures in the schools. We have worked mental health issues into the curriculum right down to the fourth grade where they begin to talk about feelings and affective things, and this continues right into high school.

When district personnel started to build the program, they could find no models on which to base their efforts. They started small and gradually built the comprehensive program now in place. After nearly seven years, school personnel follow the policies automatically.

Design of the Program

The process of establishing the program began with a review of literature to assemble essential information. This was especially necessary for committee members without a mental health background. Also at this phase, the committee gathered information about suicide among adolescents in the community. The information was used to build profiles of children who might be at risk. The committee discovered that national trends did not always hold true for students in Fairfax County. This information also helped identify certain times of the school year during which the staff should be especially vigilant for possible suicide attempts.

A second preliminary step was to prepare a list of all the mental health agencies and practitioners in the community. These were later asked to assist in the development and implementation of the program.

The next step was to appoint an advisory committee to make recommendations for the design of the program and to identify the resources needed to implement it. This committee consisted of principals, staff from the central office administration, medical professionals, social workers, psychologists, school guidance counselors, police officers, parents, staff from the Department of Social Services, and school nurses. The most urgent need was to design effective activities that would not impinge on a school day already crowded with academic and extracurricular activities. The committee concluded that the first objective should be to train the faculties of the secondary schools in suicide awareness and prevention. They also recommended that presentations, to be conducted jointly by a member of the school staff and a community mental health professional, be held for parents throughout the school year. The committee also recommended a variety of information and prevention activities designed especially for students.

Implementation of the Program

For the implementation phase, responsibility was divided among the agencies and individuals who had agreed to participate. Thus, the school system was responsible for overall management of the program, for publicizing it, for informing and training principals and other staff, and for communicating with parent-teacher associations. The community mental health centers assumed responsibility for assigning mental health professionals as speakers or group leaders. The mental health association agreed to find locations in the communities for the parent programs. The medical association helped recruit members of the medical community as speakers and kept the committee informed of attempted suicides who came to the hospitals.

Various programs were initially organized in the schools. First, some teachers were trained in suicide awareness and in leading student discussions of depression, stress, and problem-solving. Second, a number of mental health professionals spoke to classes in the school. Third, an elective peer counseling course was developed to train students to work with other students. Teachers were also trained to support the work of the students. Finally, a staff psychologist developed a workshop entitled "Dealing with Feelings of Hopelessness," which she presented to classes at the request of teachers.

On the basis of the initial year's activities, the program was extended to include all intermediate schools (grades 7 and 8). During the third year, the program expanded the activities geared for students. In the fourth year, as in the first year, awareness sessions were held for faculty members. The fifth year saw the addition of a program for elementary school students, and an inservice session was held for school mental health staff on depression and self-destructive behavior in elementary children. Because of changes in both staff and students, the major components of the program are repeated at least once every three years.

Focus on Student Development

The program does not focus exclusively on suicide. Instead, it focuses on topics relevant to the developmental issues of students at various ages. For example, students in the lower grades talk about depression and self-destructive behavior rather than suicide per se. Even in the upper grades, the focus is on several stress-related problems, only one of which is suicide.

Curricular additions were started in the seventh and eighth grades, with discussion groups focusing on many of the factors present in students who are at risk. Emphasis is placed on the social and emotional issues of adolescents. In the high schools, a student stress program was developed to prepare groups of students to make panel presentations to teachers, parents, and other students. The presentations deal with issues that are stressful for teenagers, and participants use their own experiences to generate discussion. The students also share coping mechanisms that have been effective for them. Students seem to gain confidence from the group's support and seem glad to have an audience. It is the Fairfax experience that "far from being reticent, adolescents speak out clearly when given the opportunity."

High school students who have completed a stress program may also be invited to make presentations to younger students. This ties in with the peer helper (counseling) program, as the social workers for the intermediate grades are group leaders for the peer helper program.

An elective course designed to train peer counselors is offered. The trainer presents concepts and theory, and students, with supervision, practice skills and critique peers' performance. This program provides the school staff an opportunity to help students develop interpersonal and support skills for assisting other students to grow socially, emotionally, and academically.

Peer counselors receive ongoing supervision and are trained to immediately report any high-risk behavior or threats or hints of suicide to an adult supervisor.

The district is convinced of the efficacy of this comprehensive program, though it has never had "a hard, scientific evaluation of the program," Herbert said. Some university groups have expressed an interest in doing an evaluation, which she would welcome. It is difficult to determine whether any program of this nature is preventing suicides. For example, last year there was a cluster of suicides, but this year only one death. But, as Herbert points out,

there is no question that we have a better safety net for kids, and more kids are getting help. The counseling departments have reported that the referrals from teachers have quadrupled over the past few years, and the mental health centers have told us that the referrals from schools have doubled or tripled over the past few years. So we are getting help to more kids and their families who are in trouble.

To obtain a booklet produced by the Fairfax County Public Schools, *The Adolescent Suicide Prevention Program: A Guide for Schools and Communities*, see the school district's address in the Appendix.

Summary

This chapter has described several successful suicide prevention and stress management programs. Although they differ in approach, all are based on the contention that well-organized programs implemented by dedicated, trained individuals will have a positive effect on students and the community. Districts that wish to begin their own programs can selectively incorporate components of these and other programs to meet their particular needs.

Conclusion and Recommendations

Suicide is a complex and emotionally sensitive topic that demands attention in school districts across the nation. According to Dr. Barry Garfinkel, the most important thing is to recognize that there is a problem and that action must be taken. In his opinion,

the school district is the appropriate level for action. Superintendents are the ones who must take the lead in raising the level of staff awareness and in committing the school district to respond with the appropriate resources and policies. Without their efforts to control and direct school policy, the needed changes will never occur. (Quoted by Frymier 1988)

Unlike a few years ago when there was a reluctance to discuss suicide, let alone address it through a school program, suicide prevention programs are becoming more common. State departments of education are further developing and revising programs, in cooperation with other state agencies. For example, the Wisconsin Chapter on Youth Suicide Prevention lists thirteen standards for suicide prevention that every community should have. According to standard 10, communities should have

schools, both public and private, with ongoing suicide prevention programs including, but not limited to:

- a. a written suicide prevention plan including primary prevention, crisis intervention and postintervention strategies
- b. trained staff to respond in times of crisis
- c. K-12 curriculum with focus on primary prevention and intervention strategies
- d. public knowledge and support of the program
- e. a means of evaluating and upgrading the program periodically

- f. working linkages with other community agencies (i.e., mental health, clergy, nurses, police, etc.) (Berkan 1986)

I asked several of the people interviewed for this Bulletin to advise their colleagues around the country who wish to start and operate stress and suicide prevention programs. The following sections present their recommendations in the areas of community involvement, staff training, and program evaluation and also cite some sources of additional information.

Community Involvement

According to Myra Herbert of the Fairfax County Public Schools, "the first step, without question, is to get together everybody in the community who has anything to do with youth. You get together all departments who are in any way involved. That's how we got started."

Although Herbert notes that the programs that work best are school initiated, she believes it

is very important to involve the mental health agencies, the police, the health department, mental health associations, medical associations, and to really sit down and talk. But there can be "territorial" attitudes in schools and the community agencies that make it difficult to bring them together. All such problems must be laid bare before you can have an honest, constructive process.

As a result of this interaction, for the entire period that the Fairfax County program has been in operation, they "have had tremendous support from the community and a lot of appreciation," Herbert said.

Staff Training

Staff training is the next important step, especially for small districts, says Kelli Schwab. The teachers in the building must be aware of what the counselors are trying to accomplish, and support their efforts. And in times of financial crisis, they should also see the work of the counselor as important and support the idea that the schools have counseling available, even if it means fewer funds for academic materials. Another important factor is having the principal carry out public relations for the program.

According to Dr. James Eyman of the Menninger Memorial Hospital, the people who teach stress management/suicide prevention programs must be trained in that area. If it is left to a health teacher or P.E. teacher who does not have the necessary knowledge and expertise, the program will be less effective.

If a district wants to start gradually, Herbert contends that two things

are critical. The first, she says, is a crisis procedures program that would train personnel to recognize problems and handle emergencies. According to Herbert, the second vital area is a student stress program that provides students with the opportunity to share what they are going through and to "tune in their parents." She is surprised at the number of parents who are "uninformed, really uninformed, about what is going on with kids." With a number of models now available, Strawser believes that districts should gather information about these programs and then select and modify those that will best meet their needs.

Program Evaluation

Formal and systematic evaluation of programs is one of the recommendations of the study by Kim Smith and others (1988). Few districts are doing this, however. Jeanne Harper of Alpha-Omega Ventures in Wisconsin is surveying programs in that state's 432 districts. Rather than simply describe the programs, the survey is meant to be an evaluative checklist to help schools determine what they are lacking. The results will indicate how the schools rate themselves according to the items presented. Harper is also organizing a survey to try to discover whether various social service agencies are keeping adequate records of suicides.

Evaluation of programs is essential, in her opinion, and perhaps the best way to do that is to find if they are meeting the needs of their clients—the students. If counseling is planned on the basis of fact sheets students complete before an intervention, the test of the effectiveness of the counseling is whether the factors on the sheet are successfully dealt with by the end of the intervention.

Sources of Information

Keeping informed of recent programs can be accomplished by attending conferences where presentations about successful programs are made. For example, in April 1989, a convention of the American Association of Suicidology will be held in San Diego. (Information and details can be obtained from its Denver office, listed in the Appendix.) In a preconvention course, Myra Herbert will describe the Fairfax County program and how it was formed. She has also been sent to numerous places to speak by Phi Delta Kappa. Districts with limited resources may contact Phi Delta Kappa or its local chapters to request a presentation.

Annual conferences by such organizations as Our Other Youth (address in Appendix) provide information about topics related to distress management. For example, the organization's eighth annual conference, recently held at the Red Lion Inn at the Quay in Vancouver, Washington, on February 3 and 4, included presentations on self-esteem development in

elementary and secondary schools, school climate for success, school and district policies' impact on at-risk youth, teaching self-pride, tactics for kids who say they don't care, and so forth.

Public demand to know more about youth suicide and how it can be prevented has led to a number of publications, some of which have been cited in this Bulletin. The Wisconsin Department of Public Instruction has produced a publication (available from its publications office listed in the Appendix), *Suicide Prevention: A Resource and Planning Guide* (Berkan 1986). It outlines "ways to help school districts and communities better meet the needs of troubled youth in a variety of areas. . . and. . . to help school districts and local communities establish local suicide prevention programs." In addition to describing the Wisconsin approach—a community-based, school-focused program—the guide deals with how to plan and implement a prevention program, and also what to do as postintervention—dealing with the aftermath of a completed suicide. Four model programs in the state are described, including publications that the districts send to parents and students. Appendix E of the publication provides a suicide prevention resource list of sources of audiovisual materials, books and booklets, program materials, and pamphlets. Also included are model worksheets for planning community resources networks, conducting a general community assessment, and making action plans.

Publications on suicide are also available from Phi Delta Kappa (see the Appendix). These include a 32-page report, *Responding to Adult Suicide* (which provides policy guidelines and step-by-step procedures for school personnel who must handle the trauma of a student's suicide); the Phi Delta Kappa *Current Issues Memo* on "Responding to Student Suicide: The First 48 Hours"; and a volume in its Hot Topics series titled *Adolescent Suicide* (a 251-page volume containing articles that have been selected to reflect the best of current suicide research).

The Time for Decision

Our most valuable resource is our next generation. If some of the most talented members of that generation are eliminating themselves from society because they feel they are encountering stress and difficulties with which they cannot cope, it is a message to contemporary educators that the development of academic programs in schools is not sufficient. Schools must realistically be seen as environments where our youngsters *live* their lives, not just prepare for an unseen future.

In a society that recognizes the importance of professional psychological support mechanisms for its adult members, it should not be difficult to accept that young people may also need professional assistance. We can decide either to provide hope and support to students or to deny them the assistance that could make the difference between life and death for some young people.

Appendix

Resource Agencies

American Association of Suicidology
2459 South Ash
Denver, Colorado 80222
(303) 692-0985

Center for Cognitive Therapy
Room 602
133 South 36th Street
Philadelphia, Pennsylvania 19104
(215) 898-4100

Fairfax County Public Schools
10310 Layton Hall Drive
Fairfax, Virginia 22030
(703) 246-7741

Larry Marcus
1815 251 Street
Bayside, New York 11360
(718) 658-5066 - office
(718) 423-3688 - home

Mental Health Association
1391 N. Speer Blvd., Suite 350
Denver, Colorado 80204
(303) 595-3500

National Association for Mental Health
1021 Prince St.
Alexandria, Virginia 22314
(703) 684-7722

Oregon Research Institute
1715 Franklin Blvd.
Eugene, Oregon 97403
(503) 345-6505

Our Other Youth
3301 77th Avenue NW
Gig Harbor, Washington 98335

Phi Delta Kappa
P.O. Box 789
Bloomington, Indiana 47402-0789
(812) 339-1156

The Psychological Corporation
P.O. Box 9959
San Antonio, Texas 78204-0959
(800) 233-5682

Publications Sales Office
Wisconsin Department of Public
Instruction
125 South Webster Street
P.O. Box 7841
Madison, Wisconsin 53707
(608) 266-1098

Suicide Information and Education
Center
201-723 14th St., N.W.
Calgary, Alberta T2N 2A4
Canada
(403) 425-3900

Suicide Prevention Center, Inc.
P.O. Box 1393
Dayton, Ohio 45401
(513) 223-4777

Youth Suicide National Center
1825 Eye St. N.W., Suite 400
Washington, D.C. 20006

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Interviews

- James R. Eyman, Staff Psychologist and Director of Suicide Research Program, C.F. Menninger Memorial Hospital, Topeka, Kansas. Telephone interview October 27, 1988.
- Jon Garlinghouse, Psychologist, Eugene, Oregon. Telephone interview January 20, 1989.
- Jeanne M. Harper, Alpha Omega Ventures, Marinette, Wisconsin; and Coordinator of the Wisconsin Chapter on Youth Suicide Prevention. Telephone interview December 21, 1988.
- Myra Herbert, Chief Social Worker for the Fairfax County Public Schools, Fairfax, Virginia. Telephone interview January 13, 1989.
- Suzanne Kutch, Health Promotion Consultant, State of Oregon Department of Education, Salem, Oregon. Telephone interview October 27, 1988.
- Larry Marcus, Clinical Social Worker, New York City Board of Education, Queens, New York. Telephone interview January 23, 1989.
- Paul Rohde, Coordinator of Adolescent Coping with Depression Program, Oregon Research Institute, Eugene, Oregon. Interview October 19, 1988.
- Kelli Schwab, At Risk Coordinator, South Eugene High School, Eugene, Oregon. Telephone interview January 12, 1989.
- Linda Lee Sattem, Executive Director, Suicide Prevention Center, Inc., Dayton, Ohio. Telephone interview October 26, 1988.
- Mary Ellen Strawser, Supervising Counselor, Peer Counseling Program, Coral Park Senior High School, Miami, Florida. Telephone interview January 13, 1989.
- Vicky Stromee, Assistant Director, Information & Referral Service, Inc., Tucson, Arizona. Telephone interview October 20, 1988.

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